CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Ellen M. Hesen
Acting Secretary

Shawn M. Crouch
Commissioner

December 28, 2007

Renard L. Murray, D.M.
Associate Regional Administrator
Centers for Medicare and Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Dr. Murray:

Kentucky Title XIX State Plan Transmittal No. 07-010
Inpatient Reimbursement

Enclosed for your review and approval is Kentucky Title XIX Transmittal Number 07-010. This plan amendment changes inpatient reimbursement in response to several state regulation changes. The Inpatient reimbursement amendment addresses Diagnosis Related Group (DRG), Non-DRG/Per Diem, and Disproportionate Share Hospital (DSH) reimbursement.

If additional information is needed, please contact my office at 502-564-4321.

Sincerely,

Carrie Banks on behalf of Shawn Crouch

Shawn M. Crouch
Commissioner

Enclosure

SC/NW/SO/KS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 07-010

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 15, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Chapter 412, Chapter 413 and 447.200, 447.250, 447.271, and 447.272; 42 U.S.C. §1395ww(d), 42 U.S.C. §1396r-4(a).

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 cost $14,020,000
b. FFY 2009 cost $14,020,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-A pages 1-38;
Delete Att. 4.19-A pages 7.1-7.8, 10.1, 12.1, 14.1; and
Delete Att. 4.19-A Exhibit A pages 100.01- 117.09

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
This plan amendment changes inpatient reimbursement in response to several state regulation changes.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
signed Barbara on behalf of Shawn Crouch

13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: December 28, 2007

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

(1) General Overview

Beginning October 1, 2007, the Department will pay for inpatient hospital services in general acute care hospitals under a revised DRG-based methodology. The methodology is similar to the Medicare Prospective Payment System. The revised system will have hospital specific operating and capital base rates, and Kentucky specific relative weights.

Certain facilities and services are excluded from the DRG methodology and will continue under a prospective per diem methodology. The following will be excluded from the DRG methodology:
A. Critical access hospitals;
B. Freestanding rehabilitation hospitals;
C. Long-term care hospitals;
D. Psychiatric services in acute care hospitals;
E. Psychiatric hospitals; and
F. Transplants, other than kidney, pancreas, and cornea.

(2) Acute Care Hospital Services

A. DRG-Based Methodology

1. An in-state acute care hospital shall be paid for an inpatient acute care service on a fully-prospective per discharge basis.

2. For an inpatient acute care service in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:

    a. A DRG base payment;
    b. If applicable, a high volume per diem payment; and
    c. If applicable, a cost outlier payment amount.

3. A DRG shall be based on the Medicare grouper in effect in the Medicare inpatient prospective payment system at the time of rebasing.

    For a rate effective upon the effective date of this administrative regulation, the department shall assign to the base year claims data, DRG classifications from Medicare grouper version twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006.

4. A DRG base payment shall be calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight.

5. a. The department shall determine a base rate by calculating a case mix, outlier payment and budget neutrality adjusted cost per discharge for each in-state acute care hospital as described in subsections (5) through (10) of this section.

    b. A hospital specific cost per discharge used to calculate a base rate shall be based on base year inpatient paid claims data.

    c. For a rate effective upon the effective date of this administrative regulation, a hospital specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.

6. a. The department shall calculate a cost to charge ratio for the fifteen (15) Medicaid and Medicare cost centers displayed in Table 1 below.

b. If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is above or below three (3) standard deviations from the mean of a log distribution of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk		
Kentucky Medicaid Cost Center	Kentucky Medicaid Cost Center Description	Medicare Cost Report Standard Cost Center
1	Routine Days	25
2	Intensive Days	26, 27, 28, 29, 30
3	Drugs	48, 56
4	Supplies or equipment	55, 66, 67
5	Therapy services excluding inhalation therapy	50, 51, 52
6	Inhalation therapy	49
7	Operating room	37, 38
8	Labor and delivery	39
9	Anesthesia	40
10	Cardiology	53, 54
11	Laboratory	44, 45
12	Radiology	41, 42
13	Other services	43, 46, 47, 57, 58, 59, 60, 61, 62, 63, 63.5, 64, 65, 68
14	Nursery	33
15	Neonatal intensive days	30

7. a. For a hospital with an intern or resident reported on its Medicare cost report, the department shall calculate allocated overhead by computing the difference between the costs of interns and residents before and after the allocation of overhead costs.

b. The ratio of overhead costs for interns and residents to total facility costs shall be multiplied by the costs in each cost center prior to computing the cost center cost-to-charge ratio.

8. For an in-state acute care hospital, the department shall compile the number of patient discharges, patient days, and total charges from the base year claims data. The department shall exclude from the rate calculation:

   a. Claims paid under a managed care program;
   b. Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;
   c. Transplant claims; and
   d. Revenue codes not covered by the Medicaid Program.

9. a. The department shall calculate the cost of a base year claim by multiplying the charges from each accepted revenue code by the corresponding cost center specific cost-to-charge ratio.

   b. The department shall base cost center specific cost-to-charge ratios on data extracted from the most recently, as of June 1, finalized cost report.

   c. Only an inpatient revenue code recognized by the department shall be included in the calculation of estimated costs.

10. Using the base year Medicaid claims referenced in subsection (8) of this Section, the department shall compute a hospital specific cost per discharge by dividing a hospital's Medicaid costs by its number of Medicaid discharges.

11. The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's specific cost per discharge by the hospital's case mix, expected outlier payments and budget neutrality.

    a. A hospital's case mix adjusted cost per discharge shall be calculated by dividing the hospital's cost per discharge by its case mix index; and

       The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in subsection (8) of this section.

    b. A hospital's case mix adjusted cost per discharge shall be multiplied by an initial budget neutrality factor.

       The initial factor for a state fiscal year 2007 rate shall be 0.6962 for all hospitals.

       When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.

    c. Each hospital's case mix and initial budget neutrality adjusted cost per discharge shall be multiplied by a hospital-specific outlier payment factor.

       A hospital-specific outlier payment factor shall be the result of the following formula:
       ((expected DRG non-outlier payments) - (expected proposed DRG outlier payments))/(expected DRG non-outlier payments).

d. A hospital's case mix, initial budget neutrality and outlier payment adjusted cost per discharge shall be multiplied by a secondary budget neutrality factor.

The secondary factor for a hospital for state fiscal year 2007 shall be 1.0744.

When rates are rebased, the secondary budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.

12. a. The department shall make a high volume per diem payment to an in-state acute care hospital with high Medicaid volume for base year covered Medicaid days referenced in subsection (8) of this Section.

b. High volume per diem criteria shall be based on the number of Kentucky Medicaid days or the hospital's Kentucky Medicaid utilization percentage.

c. A high volume per diem payment shall be made in the form of a per diem add-on amount in addition to the DRG base payment rate encompassing the DRG average length-of-stay days per discharge.

The payment shall be equal to the applicable high volume per diem add-on amount multiplied by the DRG average length-of-stay associated with the claim's DRG classification.

d. The department shall determine a per diem payment associated with Medicaid days-based criteria separately from a per diem payment associated with Medicaid utilization-based criteria.

If a hospital qualifies for a high volume per diem payment under both the Medicaid days-based criteria and the Medicaid utilization-based criteria, the department shall pay the higher of the two (2) add-on per diem amounts.

e. The department shall pay the indicated high volume per diem payment if either the base year covered Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient days utilization percent meet the criteria established in Table 2 below:

Table 2 - High Volume Adjustment Eligibility Criteria

Table 2 – High Volume Adjustment Eligibility Criteria			
Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
0 – 3,499 days	$0 per day	0.0% - 13.2%	$0.00 per day
3,500 – 4,499 days	$22.50 per day	13.3% - 16.1%	$22.50 per day
4,500 – 7,399 days	$45.00 per day	16.2% - 21.6%	$45.00 per day
7,400 – 10,999 days	$129.00 per day	21.7% - 27.2%	$81.00 per day
11,000 – 19,999 days	$172.00 per day	27.3% - 100.00%	$92.75 per day
20,000 and above days	$306.00 per day		

f. The department shall use base year claims data referenced in subsection (8) of this section to determine if a hospital qualifies for a high volume per diem add-on payment.

g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

13. a. The department shall make an additional cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each diagnostic category.

b. A cost outlier shall be subject to QIO review and approval.

c. A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.

d. The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

A Medicare operating or capital-related cost-to-charge ratio shall be extracted from the CMS IPPS Pricer Program.

e. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

The fixed loss cost threshold shall equal $29,000.

f. A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

14. The department shall calculate a Kentucky Medicaid-specific DRG relative weight by:

a. Selecting Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this section; and

For a rate effective upon the effective date of this administrative regulation, a hospital-specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data;

b. Reassigning the DRG classification for the base year claims based on the Medicare DRG in effect in the Medicare inpatient prospective payment system at the time of rebasing; and

For a rate effective upon the effective date of this administrative regulation, the department shall assign to the base year claims data the Medicare grouper version twenty-four (24) DRG classifications which were effective in the Medicare inpatient prospective payment system as of October 1, 2006;

c. Removing the following claims from the calculation:

Claims data for a discharge reimbursed on a per diem basis including:

A psychiatric claim, defined as follows:

(i) An acute care hospital claim with a psychiatric DRG;
(ii) A psychiatric distinct part unit claim; and
(iii) A psychiatric hospital claim;

A rehabilitation claim, defined as follows:

(i) An acute care hospital claim with a rehabilitation DRG;
(ii) A rehabilitation distinct part unit claim; and
(iii) A rehabilitation hospital claim;

A critical access hospital claim; and

A long term acute care hospital claim;

A transplant service claim as specified in subsection (19) of this Section;

A claim for a patient discharged from an out-of-state hospital; and

A claim with total charges equal to zero (0);

d. Calculating a relative weight value for a low volume DRG by:

Arraying a DRG with less than twenty-five (25) cases in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system at the same time as the Medicare DRG grouper version, published in the Federal Register, relied upon for Kentucky DRG classifications; and

For a rate effective upon the effective date of November 14, 2007, the department shall use the Medicare DRG relative weight which was effective in the Medicare inpatient prospective payment system as of October 1, 2006;

Grouping a low volume DRG, based on the Medicare DRG relative weight sort, into one (1) of five (5) categories resulting in each category having approximately the same number of Medicaid cases;

Calculating a DRG relative weight for each category; and

Assigning the relative weight calculated for a category to each DRG included in the category;

e. Standardizing the labor portion of the cost of a claim for differences in wage and the full cost of a claim for differences in indirect medical education costs across hospitals based on base year Medicare rate components;

For a rate effective upon the effective date of November 14, 2007, base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and

Base year Medicare rate components used in the Kentucky inpatient prospective payment system include:

(i) Labor-related percentage and non-labor-related percentage;
(ii) Operating and capital cost-to-charge ratios;
(iii) Operating indirect medical education costs; or
(iv) Wage indices;

The department shall standardize costs using the following formula:
standard cost = [((labor related percentage X costs)/Medicare wage index) + (nonlabor related percentage X costs)]/(1 + Medicare operating indirect medical education factor); and

For a rate effective upon the effective date of this administrative regulation, the labor related percentage shall equal sixty-two (62) percent and the nonlabor related percentage shall equal thirty-eight (38) percent;

f. Removing statistical outliers by deleting any case that is:

Above or below three (3) standard deviations from the mean cost per discharge; and

Above or below three (3) standard deviations from the mean cost per day;

g. Computing an average standardized cost for all DRGs in aggregate and for each DRG, excluding statistical outliers;

h. Computing DRG relative weights:

For a DRG with twenty-five (25) claims or more by dividing the average cost per discharge for each DRG by the statewide average cost per discharge; and

For a DRG with less than twenty-five (25) claims by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge; and

(i) Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG based on the base year claims data used to calculate DRG relative weights.

15. The department shall:

    a. Separately reimburse for a mother's stay and a newborn's stay based on the diagnostic category assigned to the mother's stay and to the newborn's stay;

    b. Establish a unique set of diagnostic categories and relative weights for an in-state acute care hospital identified by the department as qualifying as a level II or a level III non-state neonatal center or a level III non-state teaching center or a level III state teaching center as follows:

       The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:

       (i) DRG 675-680 for an in-state acute care hospital with a level II neonatal center; and

       (ii) DRG 685-690 for an in-state non-state, non-teaching acute care hospital with a level III neonatal center;

       (iii) DRG 785-790 for an in-state non-state teaching acute care hospital with a level III neonatal center; and

       (iv) DRG 885-890 for an in-state acute state teaching care hospital with a level III neonatal center.

       The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and

       The department shall compute a separate relative weight for a level II or III neonatal intensity care unit (NICU) neonatal DRG;

       The department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights for DRGs 675-680; and

       The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.

       The department shall use base year claims adjusted for base year costs to establish relative weights for respective level III neonatal centers to calculate relative weights for DRGs 785-790 and 885-890.

16. If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

    a. For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

The department shall calculate an average daily rate by dividing the DRG base payment by the statewide Medicaid geometric mean length-of-stay for a patient's DRG classification.

If a hospital qualifies for a high volume per diem add-on payment in accordance with Section 2(12) of this administrative regulation, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.

Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

b. For a hospital receiving a transferred patient, the department shall reimburse the DRG base payment, and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

17. The department shall treat a transfer from an acute care hospital to a qualifying postacute care facility for selected DRGs in accordance with paragraph (b) of this subsection as a postacute care transfer.

a. The following shall qualify as a postacute care setting:

A psychiatric, rehabilitation, children's, long-term, or cancer hospital;
A skilled nursing facility; or
A home health agency.

b. A DRG eligible for a postacute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(C)(i).

c. The department shall pay each transferring hospital an average daily rate for each day of stay.

A payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

A DRG identified by CMS as being eligible for special payment shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay, up to the full DRG base payment.

The remaining DRGs as referenced in paragraph (b) of this subsection shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.

d. The per diem amount shall be the base DRG payment allowed divided by the statewide Medicaid geometric mean length of stay for a patient's DRG classification.

18. The department shall reimburse for an intrahospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit:

a. The full DRG base payment allowed; and

b. The facility-specific distinct part unit per diem rate, in accordance with 907 KAR 1:815, Non-DRG hospital reimbursement, for each day the patient remains in the distinct part unit.

19. a. The department shall reimburse for a kidney, cornea, pancreas, or kidney and pancreas transplant on a prospective per discharge method according to the patient's DRG classification.

b. A transplant not referenced in paragraph (a) of this subsection, shall be reimbursed in accordance with 907 KAR 1:350, Coverage and payments for organ transplants.

A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

1. Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and

2. Exclude a service furnished by a home health agency, a skilled nursing facility or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

1. If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to 42 C.F.R. 447.201(c) or other federal regulation or law, the department shall not reimburse for direct graduate medical education costs.

2. If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows:

a. A payment shall be made:

(i) Separately from the per discharge and per diem payment methodologies; and
(ii) On an annual basis; and

b. The department shall determine an annual payment amount for a hospital as follows:

(i) The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by each approved hospital's Medicare fiscal intermediary;

(ii) The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected;

(iii) The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount is an estimate of total approved direct graduate medical education costs;

(iv) The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized cost report on Worksheet D, Part 1, to determine an average approved graduate medical education cost per day amount;

(v) The average graduate medical education cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data to determine the total graduate medical education costs related to the Medicaid Program; and

(vi) Medicaid Program graduate medical education costs shall then be multiplied by the budget neutrality factor.

Budget Neutrality Factors.

1. When rates are rebased, estimated projected reimbursement in the universal rate year shall not exceed payments for the same services in the prior year adjusted for inflation using the inflation factor prepared by GII for the universal rate year and adjusted for changes in patient utilization.

2. The estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year shall be estimated from base year claims.

3. The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from base year claims.

4. If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rate shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total adjusted payments in the year prior to the universal rate year.

Reimbursement Updating Procedures.

1. The department shall annually, on July 1, use the inflation factor prepared by GII for the universal rate year to inflate a hospital-specific base rate for rate years between rebasing periods.

2. Except for an appeal in accordance with Section 18 of this administrative regulation, the department shall make no other adjustment.

3. The department shall rebase DRG reimbursement every four (4) years.

Use of a Universal Rate Year.

1. A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.

2. A hospital shall not be required to change its fiscal year to conform with a universal rate year.

Cost Reporting Requirements.

1. An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP-4 as follows:

   a. A cost report shall be submitted:

      (i) For the fiscal year used by the hospital; and
      (ii) Within five (5) months after the close of the hospital's fiscal year; and

   b. Except as follows, the department shall not grant a cost report submittal extension:

      (i) If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or

      (ii) If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.

2. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

3. A cost report submitted by a hospital to the department shall be subject to audit and review.

4. An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

Unallowable Costs.

1. The following shall not be allowable cost for Medicaid reimbursement:

   a. A cost associated with a political contribution;

   b. (i) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services.

      (ii) A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

   c. (i) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity.

      (ii) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.

      (iii) If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.

2. A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.

3. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

Trending of a Cost Report for DRG Re-basing Purposes.

1. An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or unaudited, shall be trended to the beginning of the universal rate year to update a hospital's Medicaid cost.

2. The department shall use the inflation factor prepared by GII as the trending factor for the period being trended.

Indexing for Inflation.

1. After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

2. The department shall use the inflation factor prepared by GII as the indexing factor for the universal rate year.

Readmission.

1. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

2. Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

Reimbursement for Out-of-state Hospitals.

1. The department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state, for inpatient care:

   a. On a fully-prospective per discharge basis based on the patient's diagnostic category; and

   b. An all-inclusive rate.

2. The all-inclusive rate referenced in subsection 1(b) of this section shall:

   a. Equal the facility-specific Medicare base rate multiplied by the Kentucky-specific DRG relative weights, except that the DRG relative weights shall exclude any adjustment for in-state hospitals pursuant to 2006 Ky. Acts ch. 252;

   b. Exclude:

      (i) Medicare indirect medical education cost or reimbursement;
      (ii) High volume per diem add-on reimbursement;
      (iii) Disproportionate share hospital distributions; and
      (iv) Any adjustment mandated for in-state hospitals pursuant to state statute; and

c. Include a cost outlier payment if the associated discharge meets the cost outlier criteria established in state regulation;

(i) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;

(ii) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;

(iii) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year; and

(iv) The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

3. The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, an all-inclusive rate equal to the average all-inclusive base rate paid to in-state children's hospitals.

4. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.

5. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.

   a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.

   b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.

   c. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.

   d. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

Supplemental Payments.

1. In addition to a payment based on a rate developed under Section 2 of this administrative regulation, the department shall make quarterly supplemental payments to:

a. A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

(i) Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

(ii) Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid recipients under the age of eighteen (18);

b. A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount:

(i) Equal to the difference between payments made in accordance with Sections 2, 3 and 4 of this administrative regulation and the amount allowable under 42 C.F.R. 447.272, not to exceed the payment limit as specified in 42 C.F.R. 447.271;

(ii) That is prospectively determined with no end of the year settlement; and

(iii) Based on the state matching contribution made available for this purpose by a facility that qualifies under this paragraph; and

c. A hospital that qualifies as an urban trauma center hospital in an amount:

(i) Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph;

(ii) Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph;

(iii) That is prospectively determined with an end of the year settlement; and

(iv) That is consistent with the requirements of 42 C.F.R. 447.271.

2. The department shall make quarterly supplemental payments to the Appalachian Regional Hospital system in an amount that is equal to the lesser of:

a. The difference between what the department pays for inpatient services pursuant to Sections 2, 3 and 4 of this administrative regulation and what Medicare would pay for inpatient services to Medicaid eligible individuals; or

b. $7.5 million per year in aggregate.

3. A quarterly payment to a hospital in the Appalachian Regional Hospital System shall be based on its Medicaid claim volume in comparison to the Medicaid claim volume of each hospital within the Appalachian Regional Hospital System.

4. A supplemental payment made in accordance with subsection (2) of this section shall be:

a. For a service provided on or after July 1, 2005; and

b. Subject to the availability of coal severance funds that supply the state's share to be matched with federal funds.

5. An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility.

6. For the purpose of this section of the state plan, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described in state regulation, Demonstration project: services provided through regional managed care partnerships (1115 Waiver).

7. A payment made under this section of this administrative regulation shall not duplicate a payment made via the Disproportionate share hospital distributions.

8. A payment made in accordance with this section of the state plan shall be in compliance with the limitations established in 42 C.F.R. 447.272.

Certified Public Expenditures.

1. The department shall reimburse an in-state public government-owned or operated hospital the full cost of an inpatient service via a certified public expenditure (CPE) contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

2. To determine the amount of costs eligible for a CPE, a hospital's allowed charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

3. The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

4. a. Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for the period.

   b. If any difference remains, the department shall reconcile any difference with the provider.

Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

1. The contract shall contain a provision granting the department access:

   a. To the subcontractor's financial information; and

   b. In accordance with 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation; and

2. Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

New Provider, Change of Ownership, or Merged Facility.

1. If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.

2. a. Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.

   b. During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

3. In the case of two (2) or more separate entities that merge into one (1) organization, the department shall:

   a. Merge the latest available data used for rate setting;

   b. Combine bed utilization statistics, creating a new occupancy ratio;

   c. Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

   d. Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting; and

   e. (i) Require each provider to submit a cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.

   (ii) A cost report for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 8 of this administrative regulation.

B. Per Diem Methodology

Payment for Rehabilitation or Psychiatric Care in an In-State Acute Care Hospital.

1. For rehabilitation care in an in-state acute care hospital that has a Medicare-designated rehabilitation distinct part unit, the department shall reimburse:

   a. A facility specific per diem based on the most recently received Medicare cost report received prior to the rate year, trended and indexed to the current state fiscal year; and

   b. In accordance with Sections 6 and 9 of this administrative regulation.

2. The department shall reimburse for psychiatric care in an in-state acute care hospital that has a Medicare-designated psychiatric distinct part unit on a per diem basis as follows:

   a. Reimbursement for an inpatient psychiatric service shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.

   b. A psychiatric per diem rate shall be the sum of a psychiatric operating per diem rate and a psychiatric capital per diem rate.

   (i) The psychiatric operating cost-per-day amounts used to determine the psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid psychiatric cost basis, excluding capital costs and medical education costs, by the number of Medicaid psychiatric patient days in the base year.

   (ii) The Medicaid psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a psychiatric diagnosis with dates of service in the base year. The psychiatric operating per diem rate shall be adjusted for:

   (a) The price level increase from the midpoint of the base year to the midpoint of the universal rate year using the CMS Input Price Index; and

(b) The change in the Medicare published wage index from the base year to the universal rate year.

c. (i) A psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid psychiatric capital cost basis by the number of Medicaid psychiatric patient days in the base year.

(ii) The Medicaid psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with psychiatric diagnoses with dates of service in the base year.

(iii) The psychiatric capital per diem rate shall not be adjusted for inflation.

3. The department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare-designated distinct part unit:

a. (i) On a facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.

(ii) Aggregate projected payments and projected Medicaid paid days shall be the sum of:

(a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in 907 KAR 1:013, Diagnostic related group (DRG) inpatient hospital reimbursement;

(b) Actual prior year payments inflated by the GII; and

(c) Per diem DRG service Medicaid days; and

b. In accordance with Sections 6 and 9 of this administrative regulation.

Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.

1. The department shall reimburse for inpatient care provided to eligible Medicaid recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabilitation hospital, or LTAC hospital on a per diem basis.

2. The department shall calculate a per diem rate by:

(i) Using a hospital's state fiscal year 2005 cost report, allowable cost and paid days to calculate a base cost per day for the hospital;

(ii) Trending and indexing a hospital's specific cost, excluding capital cost, per day to the current state fiscal year;

(iii) Calculating an average base cost per day for hospitals within similar categories, for example rehabilitation hospitals, using the indexed and trended base cost per day;

(iv) Assigning no hospital a base cost per day equaling less than ninety-five (95) percent of the weighted average trended and indexed base cost per day of hospitals within the corresponding category;

(v) Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in 907 KAR 1:013, Diagnostic related group hospital reimbursement; and

(vi) Applying available provider tax funds on a pro-rata basis to the pre-provider tax per diem calculated in paragraphs (i) through (vi) of this subsection.

Payment to a Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital.

1. The department shall reimburse a newly-participating in-state freestanding psychiatric hospital, freestanding rehabilitation hospital or long term acute care hospital the minimum per diem rate paid to hospitals in their category until the first fiscal year cost report submitted by the hospital has been finalized.

2. Upon finalization of the first fiscal year cost report for a facility, the department shall reimburse the facility a per diem rate in accordance with Section 3 of this administrative regulation.

Payment for Critical Access Hospital Care.

1. The department shall pay a per diem rate to a critical access hospital equal to the hospital's Medicare rate.

2. A critical access hospital's final reimbursement for a fiscal year shall reflect any adjustment made by CMS.

3. a. A critical access hospital shall comply with the cost reporting requirements established in state regulation.

   b. A cost report submitted by a critical access hospital to the department shall be subject to audit and review.

4. An out-of-state critical access hospital shall be reimbursed under the same methodology as an in-state critical access hospital.

5. The department shall reimburse for care in a federally defined swing bed in a critical access hospital pursuant to state regulation related to Payments for price-based nursing facility services.

Reimbursement Limit. Total reimbursement to a hospital, other than to a critical access hospital, shall be subject to the limitation established in 42 C.F.R. 447.271.

In-State Hospital Reimbursement Updating Procedures.

1. The department shall adjust an in-state hospital's per diem rate annually according to the following:

   a. An operating and professional component per diem rate shall be inflated from the midpoint of the previous universal rate year to the midpoint of the current universal rate year using the GII; and

b. A capital per diem rate shall not be adjusted for inflation.

2. The department shall, except for a critical access hospital, rebase an in-state hospital's per diem rate every four (4) years.

3. Except for an adjustment resulting from an appeal, the department shall make no other adjustment.

Use of a Universal Rate Year.

1. A universal rate year shall be established as July 1 through June 30 to coincide with the state fiscal year.

2. A hospital shall not be required to change its fiscal year to conform to a universal rate year.

Cost Basis.

1. An allowable Medicaid cost shall:

   a. Be a cost allowed after a Medicaid or Medicare audit;
   b. Be in accordance with 42 C.F.R. Parts 412 and 413;
   c. Include an in-state hospital's provider tax; and
   d. Not include a cost listed in Section 11 of this administrative regulation.

2. A prospective rate shall include both routine and ancillary costs.

3. A prospective rate shall not be subject to retroactive adjustment, except for:

   a. A critical access hospital; or
   b. A facility with a rate based on un-audited data.

4. An overpayment shall be recouped by the department as follows:

   a. A provider owing an overpayment shall submit the amount of the overpayment to the department; or

   b. The department shall withhold the overpayment amount from a future Medicaid payment due the provider.

In-State Hospital Cost Reporting Requirements.

1. An in-state hospital participating in the Medicaid Program shall submit to the department a copy of a Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP-4 as follows:

   a. A cost report shall be submitted:

      (i) For the fiscal year used by the hospital; and
      (ii) Within five (5) months after the close of the hospital's fiscal year; and

   b. Except as follows, the department shall not grant a cost report submittal extension:

(i) If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or

(ii) If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.

2. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

3. A cost report submitted by a hospital to the department shall be subject to audit and review.

4. An in-state hospital shall submit a final Medicare-audited cost report upon completion by the Medicare intermediary to the department.

Unallowable Costs.

1. The following shall not be allowable cost for Medicaid reimbursement:

   a. A cost associated with a political contribution;

   b. (i) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services.

   (ii) A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

   c. (i) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity.

   (ii) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.

   (iii) If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.

2. A hospital shall identify an unallowable cost on a Supplemental Medicaid Schedule KMAP-1.

3. A Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted to the department with an annual cost report.

Trending of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

1. An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended to the beginning of the universal rate year to update an in-state hospital's Medicaid cost.

2. The trending factor, referenced in subsection (1) of this section, to be used shall be the inflation factor prepared by GII for the period being trended.

In-State Hospital Indexing for Inflation.

1. After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

2. The department shall apply the inflation factor prepared by GII for the universal rate year as the indexing factor.

In-State Hospital Minimum Occupancy Factor.

1. If an in-state hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:

   a. Artificially increasing the occupancy factor to the minimum factor; and
   b. Calculating the capital costs using the calculated minimum occupancy factor.

2. The following minimum occupancy factors shall apply:

   a. A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100 or fewer total licensed beds;

   b. A seventy-five (75) percent minimum occupancy factor shall apply to a hospital with 101 or more total licensed beds; and

   c. A newly-constructed in-state hospital shall be allowed one (1) full universal rate year before a minimum occupancy factor shall be applied.

Reduced Depreciation Allowance. The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty-five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.

Reimbursement for Out-of-state Hospitals.

1. For inpatient psychiatric or rehabilitation care provided by an acute out-of-state hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate.

   a. The psychiatric operating per diem rate shall be the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state acute care hospitals that have licensed psychiatric beds pursuant to state regulation on Psychiatric hospitals; operation and services.

   b. The psychiatric capital per diem rate shall be the median psychiatric capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric beds pursuant to state regulation on Psychiatric hospitals; operation and services.

   c. The per diem rate shall not include any adjustment mandated for in-state hospitals pursuant to state statute.

2. For care provided by an out-of-state freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of a psychiatric operating per diem rate and a capital per diem rate.

   a. The psychiatric operating per diem rate shall equal the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.

b. The psychiatric capital per diem rate shall be the median psychiatric capital per diem rate for all in-state freestanding psychiatric hospitals.

c. The per diem rate shall not include any adjustment mandated for in-state hospitals pursuant to state statute.

3. For care in an out-of-state rehabilitation hospital, the department shall reimburse a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilitation hospitals minus any adjustment mandated for in-state hospitals pursuant to state statute.

4. The department shall apply the requirements of 42 C.F.R. 447.271 on a claim-specific basis to payments made via this section of this administrative regulation.

Supplemental Payments. In addition to a payment based on a rate developed under the Rehabilitation or Psychiatric Care in and In-State Acute Care Hospital; Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric Hospital Care, and In-State Freestanding Rehabilitation Hospital Care; and Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital sections, the department shall:

1. Make quarterly supplemental payments to an in-state hospital which qualifies as a psychiatric access hospital in an amount:

   a. Equal to the hospital's uncompensated costs of providing care to Medicaid recipients and individuals not covered by a third party payor, not to exceed $6 million annually; and

   b. Consistent with the requirements of 42 C.F.R. 447.271; and

2. Make an annual payment to an in-state state-designated free-standing rehabilitation teaching hospital that is not state-owned or operated in an amount:

   a. Determined on a per diem or per discharge basis equal to the nonreimbursed costs of providing care to Medicaid recipients;

   b. Costs shall be the amount of cost identified on a hospital's finalized cost report for a fiscal year reduced by the cost of care covered by third parties.

   c. Equal to the amount of per diem payments pursuant to state regulation or per discharge diagnostic related group payments pursuant to the state regulation on Diagnostic related group hospital reimbursement, received by the hospital for Medicaid recipients not covered by third parties.

Certified Public Expenditures.

1. The department shall reimburse an in-state public government-owned hospital the full cost of inpatient care via a certified public expenditure (CPE) contingent upon approval by CMS.

2. To determine the amount of costs eligible for a CPE, an in-state hospital's allowed charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

3. The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

4. a. Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for the period.

b. If any difference between actual cost and submitted cost remains, the department shall reconcile any difference with the provider.

Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

1. The contract shall contain a provision granting the department access:

   a. To the subcontractor's financial information; and

   b. In accordance with state regulation for Provider enrollment, disclosure, and documentation for Medicaid participation; and

2. Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

New Provider, Change of Ownership, or Merged Facility.

1. If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.

2. Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.

   a. A prospective per diem shall be set based on the operating budget and projected number of patient days for care not subject to a diagnostic related group method of reimbursement.

   b. A prospective per diem rate set in accordance with paragraph (a) of this subsection shall be tentative and subject to settlement at the time the first audited fiscal year end report is available to the department.

   c. During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

3. If two (2) or more separate entities merge into one (1) organization, the department shall:

   a. Merge the latest available data used for rate setting;

   b. Combine bed utilization statistics, creating a new occupancy ratio;

   c. Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

   d. Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting;

   e. If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid;

f. Recognize an appeal of the merged per diem rate in accordance with state regulation on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions; and

g. (i) Require each provider to submit a Medicaid cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.

(ii) A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 10 of this administrative regulation.

C. Disproportionate Share Hospital Provisions

1. Disproportionate share hospital or DSH means an in-state hospital that:

a. Has an inpatient Medicaid utilization rate of one (1) percent or higher; and
b. Meets the criteria established in 42 U.S.C. 1396r-4(d).

Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

a. Be made to a qualified hospital;

b. Be based upon available funds in accordance with state statute;

c. Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year;

d. Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall cover the state fiscal year beginning July 1, 2007 and ending June 30, 2008;

e. Not be subject to settlement or revision based on a change in utilization during the year to which it applies; and

f. Be made on an annual basis.

Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital.

1. The department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:

a. Determining a hospital's average reimbursement per discharge;

b. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;

c. Multiplying the amount established in paragraph b by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost;

d. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with state regulation related to Workers' compensation hospital fee schedule;

e. Combining the inpatient indigent care cost established in paragraph (c) with the outpatient indigent care cost established in paragraph (d) to establish a hospital's indigent care cost total; and

f. Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool pursuant to KRS 205.640(3)(d) to establish a DSH distribution on a pro rata basis.

Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation Hospital or Long Term Acute Care Hospital. The department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital:

1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:

   a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

   b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with state regulation related to Workers' compensation hospital fee schedule;

   c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

   d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state regulations related to establishing a hospital's DSH distribution on a pro rata basis; and

2. For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

   a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and

   b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with state regulation related to Workers' compensation hospital fee schedule;

   c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

   d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state statute establishing a hospital's DSH distribution on a pro rata basis.

Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. The department shall determine a DSH distribution to a private psychiatric hospital:

1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:

    a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

    b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with state regulation related to Workers' compensation hospital fee schedule or by establishing an inpatient equivalency;

    c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

    d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis; and

2. For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

    a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection 2 of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and

    b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091, Workers' compensation hospital fee schedule or by establishing an inpatient equivalency;

    c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

    d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.

Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:

1. Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in Section 9 of this administration regulation, minus any payment made by or on behalf of the individual to the hospital; and

2. Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.

3. Payments to a State Mental Hospitals shall not exceed the sum of the costs of providing inpatient and outpatient services to Medicaid patients, less the amount paid under the nondisproportionate share provisions and the costs of services to both uninsured and indigent patients, less any payments made.

Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall:

1. Be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid according to the regulation related to Diagnostic related group (DRG) inpatient hospital reimbursement, or 907 KAR 1:815, Nondiagnostic related group inpatient hospital reimbursement, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients; and

2. Be contingent upon a facility providing up to 100 percent of matching funds to receive federal financial participation for distribution under this subsection.

3. Comply with state statute.

4. Payments to a State Mental Hospitals shall not exceed the sum of the costs of providing inpatient and outpatient services to Medicaid patients, less the amount paid under the nondisproportionate share provisions and the costs of services to both uninsured and indigent patients, less any payments made.

Indigent Care Eligibility.

1. Prior to billing a patient and prior to submitting the cost of a hospital service to the department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital Program, to assess a patient's financial situation to determine if:

    a. Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or

    b. A patient meets the indigent care eligibility criteria.

2. An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program, at the hospital.

Indigent Care Eligibility Criteria.

1. A hospital shall receive disproportionate share hospital funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of this administrative regulation if the following apply:

    a. The patient is a resident of Kentucky;

    b. The patient is not eligible for Medicaid or KCHIP;

    c. The patient is not covered by a third-party payor;

    d. The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;

e. The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:

(i) The patient;
(ii) The patient's spouse;
(iii) The minor's parent or parents living in the home; and
(iv) Any minor living in the home;

f. A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;

g. Countable resources of a family unit shall not exceed:

(i) $2,000 for an individual;
(ii) $4,000 for a family unit size of two (2); and
(iii) Fifty (50) dollars for each additional family unit member;

h. Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and

i. The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.

2. Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:

a. Income received during the twelve (12) months preceding the month of receiving a service; or

b. The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).

3. A work expense for a self-employed patient shall be deducted from gross income if:

a. The work expense is directly related to producing a good or service; and
b. Without it the good or service could not be produced.

4. A hospital shall notify the patient or responsible party of his eligibility for indigent care.

5. If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

Indigent Care Eligibility Determination Fair Hearing Process.

1. If a hospital determines that a patient does not meet indigent care eligibility criteria as established in Section 9 of this administrative regulation, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.

2. If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.

3. A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:

   a. Review evidence regarding the indigent care eligibility determination;
   b. Cross-examine witnesses regarding the indigent care eligibility determination;
   c. Present evidence regarding the indigent care eligibility determination; and
   d. Be represented by counsel.

4. A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:

   a. The patient or responsible party who requested the fair hearing; and
   b. The department.

5. A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.

6. A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with state statute.

Indigent Care Reporting Requirements.

1. On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data.

2. If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.

Merged Facility. If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

Limit on Amount of Disproportionate Share Payment to a Hospital.

1. Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan. The cost of services to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

2. Funds not distributed under the above provisions due to the limit in 1. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

Medicaid Days Total Medicaid Days	X	Remaining Funds	=	DSH Payment

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). Medicaid days shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and through a managed care entity.

3. Limit on Amount of Disproportionate Share Payment to a Hospital

   a. A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)

   b. Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.

   c. Unrecovered Cost of Uninsured/indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

4. The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(3) Payment Not to Exceed Charges

A. The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges. the state will recoup payments in excess of allowable charges-plus-disproportionate share.

B. The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits.

(4) Public Process for Determining Rates for Inpatient Hospitals

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

(5) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A

B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

1. The PRTFs shall be paid a fixed per diem rate of $230 which shall be adjusted upward each biennium by 2.22 percent or the usual and customary charge, if less. The payments shall not exceed prevailing charges in the locality for comparable services provided under comparable circumstances. The fixed rate (upper limit) is the state's best estimate of the reasonable and adequate cost of providing the services. This rate is determined in the following manner:

   a. Facilities that provide services that meet the criteria for PRTFs are requested to submit their actual costs for covered services. These costs shall include all care and treatment, staffing, ancillary services (excluding drugs), capital, and room and board costs.

   b. The actual costs submitted by the facilities are compared to the costs estimated to operate a model PRTF. The costs of the model facility and current facilities are analyzed on the basis of their being reasonable and adequate to meet the costs which would be incurred in order to provide quality services in an economic and efficient manner. . .

   c. From this analysis and a consideration of the comments from the facilities, a uniform per diem rate is established for all participating facilities.

   d. This per diem rate is then adjusted for inflation by 2.22 percent biennium. This inflation rate is based upon the historic rate of inflation as applied to these facilities and their necessary increases in costs of providing the services.

2. The fixed rate or usual and customary charge, if less, covers total facility costs for PRTF services including the following: all care and treatment costs, staffing, costs for ancillary services (except drugs), capital costs, and room and board costs. The rate is established to be fair and adequate compensation for services provided to Medicaid beneficiaries.

(6) Supplement Payments

A. Intensity Operatinc Allowance Inpatient Supplement.

1. Beginning July 1, 2003, a state designated pediatric hospital that is state- owned or operated and qualifies as a State University teaching DSH hospital shall receive an enhanced payment for the current rate year. This payment shall be an amount that is equal to the difference between the payments made by Medicaid and an estimate of Medicare payments for the same services based on Medicare principles of reimbursement as specified in 42 CFR 447.272. The limitation in 42 CFR 447.272 will be applied on a facility- specific basis.

2. Any payments made under subsection A of this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

3. Payments made under this section shall be prospectively determined quarterly amounts, subject to the same limitations and conditions as above.

4. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

5. A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

   a. Determined on a per diem or per discharge basis equal to the unreimbursed costs of providing care to Medicaid recipients under the age of 18; plus

   b. $250,000 ($1 million annually).

6. Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.

B. Supplemental Payment for Urban Trauma Center Hospitals
supplemental payments are provided for State University teaching hospitals that qualify as urban trauma centers

1. A hospital qualifies as an urban trauma center if it meets the following:

   a. The hospital is designated as a Level I Trauma Center by the American College of Surgeons;

   b. The hospital has a Medicaid utilization rate greater than 25%; and

   c. At least 50% of its Medicaid population are residents of the county in which the hospital is located.

2. Medicaid utilization rate is the rate derived by dividing a hospital's total Medicaid days by the total patient days, which includes days reimbursed through a managed care entity and fee-for-service.

3. The supplemental payment amount will be determined as follows:

   Step 1: The average payment rate per Medicare case with case mix removed will be calculated by dividing all Medicare payments subject to case mix by the Medicare case mix index and adding to this amount all Medicare pass-through payments utilizing data obtained from the most recent cost report. The result will be divided by Medicare cases for the corresponding period.

   Step 2: The average payment rate per Medicaid case with case mi removed will be calculated by dividing total Medicaid payments subject to case mix by the Medicaid case mix index calculated utilizing Medicare relative weights and adding to this amount all other Medicaid payments. The result will be divided by the number Medicaid cases for the corresponding period.

Step 3: The difference between the average payment rate per Medicare case with case mix removed and the average payment rate per Medicaid case with case mix removed will be multiplied by the Medicaid case mix and the number of Medicaid cases. The result is the gap between the Upper Payment Limit (UPL) and Medicaid payments for the applicable period.

Step 4: The difference between the average charge per Medicaid case and the average Medicaid payment rate per Medicaid case will be multiplied by the number of Medicaid cases. The result is the charge gap for the applicable period.

Step 5: The total supplemental payment will be equal to the lesser of the UPL Gap calculated in Step 3 and the Charge Gap calculated in Step 4.

4. Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

5. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Centers for Medicare and Medicaid Services, the Department shall adjust the payments made to any hospitals to qualify for FFP.

C. Supplemental Payments for Psychiatric Access Hospitals

1. For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

   a. The hospital is not located in a Metropolitan Statistical Area (MSA);

   b. The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;

   c. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and

   d. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

2. Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds available for these payments. Payments will be made on a quarterly basis in according with the following:

$$\frac{\text{Medicaid patient days}}{\text{Total Medicaid patient days}} \times \text{Available Fund} = \text{Payment}$$

3. Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The available fund shall be an amount not to exceed $6 million annually.

D. Supplemental payments for non-state government-owned hospitals.

1. Commencing July 1, 2005, the Department will provide inpatient supplemental payments to non-state, government-owned hospitals for services provided to Medicaid patients. These payments will be determined by calculating the difference between the aggregate amount paid for inpatient services provided to Medicaid patients and the estimated aggregate payment amount for such services if payments were based on Medicare payment principles, or the upper payment limit gap (UPL Gap).

   The estimated aggregate payment amount for Medicaid services if payment were based on Medicare payment principles will be determined by calculating the sum of the average payments determined by applying Medicare payment principles for each hospital multiplied by the number of estimated cases for each hospital for the applicable payment period. The average payment rate under Medicare for acute care inpatient hospital stays for each hospital will be determined by calculating the hospital-specific payment rate in accordance with the Medicare Inpatient Prospective Payment system. In determining this amount the case mix index for the Medicaid population will be calculated utilizing Medicare relative weights. The average payment rate for services provided by hospital units excluded from the Medicare Inpatient Prospective Payment system will be calculated in accordance with Medicare cost based principles of reimbursement.

   The amount of the aggregate UPL Gap will be distributed to individual non-state, government-owned hospitals based on the individual hospital's fee-for-service inpatient days as a proportion of total fee-for-service inpatient days for non-state, government-owned hospitals. In the event such a payment would exceed an individual hospital's charge limit, the amount in excess of the individual hospital's charge limit will be allocated to other non-state, government-owned hospitals eligible to receive additional payments without exceeding their charge limit. Individual hospital payments may also be reduced in order to assure that an individual hospital's net payments do not exceed 2004 net payments. In the event a hospital's net payments are reduced to assure net payments do not exceed 2004 net payments, the amount in excess of the hospital's 2004 net payment will be allocated to other non-state, government- owned hospitals eligible for payment.

   Inpatient supplemental payments described above will be made at least quarterly.

   A payment made to a hospital under this provision when combined with other payments under the non-disproportionate provisions of the state plan shall not exceed the limit specified in 42 CFR 447.272.

E. All hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital system will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of $7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

   The Upper Payment Limit as defined in 42 CFR 447.272 will be calculated as follows:

1. Calculate the hospital specific case-mix index using inpatient Medicaid claims data for each facility from the data set utilized to develop Medicaid-specific relative value weights for the most recent state fiscal year as follows:

a. Assign each inpatient Medicaid claim to a Medicare DRG.

b. Total the number of claims assigned to each DRG.

c. Multiply the number of discharges for each DRG by the Medicare relative weight (include claims mapped to a psych DRG unless the facility has an excluded unit).

d. Add the results of 1.c.

e. Divide the results of 1.d by the total number of discharges.

2. Calculate the facility-specific operating payment using Medicare rates effective in the period for which payments are to be made.

a. Select the appropriate average standardized amount considering the location of the hospital (large urban or other) from Table 1A of the final rule for the applicable federal fiscal year published in the Federal Register.

b. Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

c. Add the amount from 2.b and the nonlabor-related portion of the standardized amount from the final rule for the applicable federal fiscal year published in the Federal Register.

d. Multiply the amount from 2.c by the case-mix index calculated in accordance with 1.

e. Multiply the amount from 2.d by: 1 + Operating DSH Adjustment Factor + Operating IME Adjustment factor. The adjustment factors to be applied shall be obtained from the Medicare Intermediary or CMS public use files.

3. Calculate total Operating Payments.

a. For each facility, multiply the amount from 2.e by the number of discharges from the data set utilized to develop Medicaid-specific relative value weights for the most recent state fiscal year.

b. Total the amounts calculated in 3.a.

4. Calculate the facility-specific capital payment using Medicare rates effective in the period for which payments are to be made.

a. Select the national capital standard federal payment rate from Table 1D of the final rule for the applicable federal fiscal year published in the Federal Register.

b. Multiply the national capital standard federal payment by the applicable geographic adjustment factor for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

c. Multiply the amount calculated in 4.b by the case-mix index calculated in accordance with Step 1.

d. Multiply the amount calculated in 4.c by: 1 + Capital DSH Adjustment Factor + Capital IME Adjustment factor. The adjustment factors to be applied shall be obtained from the Medicare Intermediary or CMS public use files.

5. Calculate total capital payments.

   a. For each facility, multiply the amount from 4.d by the number of discharges from the data set utilized to develop Medicaid-specific relative value weights for the most recent state fiscal year.

   b. Total the amounts calculated in 5.a.

6. Calculate outlier payments using the data set utilized to develop Medicaid- specific relative value weights for the most recent state fiscal year in accordance with the Medicare prospective payment system.

7. Calculate transfer adjustments using the data set utilized to develop Medicaid- specific relative value weights for the most recent state fiscal year in accordance with the Medicare prospective payment system.

8. Calculate facility-specific payment rate for discharges from excluded units.

   a. Select the Target Amount from Worksheet D-1 of the most recent available cost report.

   b. Inflate the target amount from 8.a by the latest CMS hospital market basket index forecast for non-PPS (exempt) hospitals published in the federal register.

9. Calculate total payments for excluded units

   a. Multiply the amount calculated in 8.b for each facility by the number of discharges from excluded units for the facility in the data set utilized to develop Medicaid-specific relative value weights for the most recent state fiscal year.

   b. Total the amounts calculated in 9.a

10. Calculate Total Estimated Payments under Medicare

    a. Total the amounts calculated in 3.b, 5.b, 6, 7, and 9.

F. Neonatal Level II Supplement Payment

1. A supplemental payment for a DRG 675 - 680 shall be made to an in-state high intensity level II neonatal center.
   a. The Department will make prospective supplemental payments to in-state hospitals for all DRGs 385 through 390 to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

      1) Is licensed for a minimum of 24 neonatal level II beds;

      2) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;

      3) Has a gestational age lower limit of twenty-seven (27) weeks; and

4) Has a full-time perinatologist on staff.

The payment will be an add-on per discharge for each of the above DRGs, and the amount of the add-on will be based on the following dates:

1) Before July 1, 2007, the add-on will be $3,775;

2) From July 1, 2007 through September 30, 2007, the add-on will be $9,853; and

3) On or after October 1, 2007, the add-on will be $2,870.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

PUBLIC NOTICE

The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS), in accordance with 42 CFR 447.205, hereby provides public notice of its intent to revise or clarify reimbursement for hospital services as follows:

Diagnostic Related Group (DRG) Hospital

Effective October 15, 2007, DMS shall reimburse DRG hospitals as follows:

- Update the base year to 2006
- Add a CMS IPPS Pricer Program – the software program published on CMS website showing Medicare rate components and payment rates under Medicare inpatient prospective payment system for a discharge within a given federal fiscal year
- Add a cost center table
- Implement a cost center specific cost-to-charge ratio which is a ratio of a hospital's cost center specific total hospital costs to its cost center specific total charges
- Add diagnostic categories – diagnostic classifications containing one or more DRGs used by Medicare programs assigned in the base year with modifications
- Uses DRG average length of to determine the payment amount for high volume adjustments
- Uses global insight incorporated (GII) as inflation adjuster rather than data resources incorporated (DRI)
- Establishes high intensity level II neonatal center criteria and reimbursement
- *Establishes a high volume per diem payment which is an add-on in addition to DRG base payment for each discharge and made to hospitals with high Medicaid utilization and tiered based on amount of Medicaid utilization*
- Establishes an outlier adjustment factor which is a hospital-specific factor used in the DRG base rate calculation to account for expected outlier payments
- Establishes a DRG base payment which:
    - is based on the DRG classifications in the Medicare grouper version 24 in effect on the Medicare inpatient prospective payment system as of October 1, 2006
    - is calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight
    - is determined by adjusting the hospital's specific cost per discharge by the hospital's case mix, expected outlier payments and budget neutrality
- Alters relative weights to reflect average cost per discharge for each DRG relative to average cost per discharge of all DRGs combined based on Kentucky-specific Medicaid fee-*for-service paid claims data*
- Use a statewide the geometric mean length of stay rather than average length of stay in determining reimbursement for hospital transfers
- Not reimburse for direct graduate medical education costs if federal financial participation is not provided for direct graduate medical education cost
- Reimburse for out-of-state children's hospital located in a metropolitan statistical area (MSA) whose boundary overlaps KY and is a border state at the average all-inclusive base rate paid to in-state children's hospitals
- Reimburse for out-of-state rural hospital equal to bottom quartile all-inclusive base rate paid to in-state rural hospitals
- Reimburse for out-of-state urban hospital equal to bottom quartile all-inclusive rate paid to in-state urban hospitals

- Establishes reimbursement for a certified public expenditure (CPE) by a publicly-owned or operated in-state hospital contingent upon Centers for Medicare and Medicaid Services (CMS) approval of the expenditure as a CPE

Non-DRG or Per Diem Hospital Reimbursement

Effective October 15, 2007, DMS shall reimburse Non-DRG (Per Diem) hospitals as follows:

- Rehabilitation hospitals with a distinct part unit (DPU) shall be reimbursed a per diem equivalent to cost reported for Medicare DPU patients based on the most recently finalized cost report prior to the rate year
- Rehabilitation hospitals without a DPU shall be reimbursed a per diem equal to aggregate projected payments for DRG services divided by its aggregate projected Medicaid covered days
- Psychiatric care in an acute care hospital with a DPU shall be reimbursed a per diem equivalent to cost reported for Medicare DPU patients based on the most recently finalized cost report prior to the rate year
- Psychiatric care in an acute care hospital without a DPU shall be reimbursed a per diem equal to aggregate projected payments for DRG services divided by its aggregate projected Medicaid covered days
- Freestanding rehabilitation hospitals, freestanding psychiatric hospitals and long term acute care (LTAC) hospitals shall be reimbursed a per diem:
    - A per diem based on their 2005 cost report representing allowable cost and paid days, trended and indexed to the current fiscal year; or
    - 90% of the average cost per day of hospitals within their same category if the given hospital's per diem is less than 90% of this average
    - Additionally, a parity factor shall be applied to a per diem equal to the aggregate cost coverage established for DRG hospital reimbursement
- Care to a child in custody of the Cabinet for Health and Family Services by freestanding rehabilitation hospitals, freestanding psychiatric hospitals and long term acute care (LTAC) hospitals shall be reimbursed the median per diem rate of all freestanding psychiatric hospitals
- Newly participating freestanding rehabilitation hospitals, freestanding psychiatric hospitals and long term acute care (LTAC) hospitals shall be reimbursed the minimum per diem paid to hospitals within their given category until the new facility's first fiscal year cost report has been finalized. After the first fiscal year cost report has been finalized, the facility will be paid a per diem as established above for freestanding rehabilitation hospitals, freestanding psychiatric hospitals and long term acute care (LTAC) hospitals
- Per diem hospital reimbursement adjustment shall be as follows:
    - Rebased every four years
    - Capital per diems shall not be adjusted
    - Operating and professional per diems shall be inflated from the midpoint of the previous universal rate year to the midpoint of the current universal rate year using the Global Insight Index (GII)
- Psychiatric care in out-of-state acute care hospitals shall be reimbursed a per diem comprised of an operating per diem and a capital per diem:
    - The operating per diem shall be the median operating cost, excluding graduate medical education, per day for all in-state acute care hospitals which have licensed psychiatric beds
    - The capital per diem shall be the median psychiatric per diem for all in-state acute care hospitals which have licensed psychiatric beds
- Rehabilitation care in out-of-state acute care hospitals shall be reimbursed the median per diem for all in-state rehabilitation hospitals

Disproportionate Share Hospital (DSH) Reimbursement

Effective October 15, 2007, DSH distributions shall be determined as follows:

Acute care hospital DSH distributions shall be determined by:

- Utilizing an acute care hospital's DRG rate to determine its indigent care costs pursuant to KRS 205.640(3)(d)1
- Annually calculating an indigent care factor for each hospital by calculating each hospital's percent of indigent care cost of total indigent care cost for all hospitals within the same pool (*indigent care cost means inpatient and outpatient care reported to the department* multiplied by its DRG rate that when multiplied by the hospital's reported indigent care equals amount that would be payable via Medicaid program for hospitals' total reported indigent care
- Calculating each hospital's annual distribution by multiplying their indigent care factor by the total money allocated to all hospitals within a given pool
- Indigent care data to be used shall be data reported by hospitals for indigent care services rendered during 12-month period ending June 30 of each year as reported by the hospital to DMS by August 15

Private psychiatric hospital DSH distributions shall be determined as follows:

- Utilizing a hospital's per diem rate to determine the hospital's indigent care costs pursuant to KRS 205.640(3)(d)1
- Annually calculating an indigent care factor for each hospital by calculating each hospital's percent of indigent care cost of total indigent care cost for all hospitals within the same pool (*indigent care cost means inpatient and outpatient care reported to the department* multiplied by the per diem rate that when multiplied by the hospital's reported indigent care equals amount that would be payable via Medicaid program for hospitals' total reported indigent care
- Calculating each hospital's annual distribution by multiplying their indigent care factor by the total money allocated to all hospitals within the given pool
- Indigent care data to be used shall be data reported by hospitals for indigent care services rendered during 12-month period ending June 30 of each year as reported by the hospital to DMS by August 15

State mental hospital DSH distributions shall be determined as follows:

- Utilizing a hospital's per diem rate to determine the hospital's indigent care costs pursuant to KRS 205.640(3)(d)1
- Annually calculating an indigent care factor for each hospital by calculating each hospital's percent of indigent care cost of total indigent care cost for all hospitals within the same pool (indigent care cost means inpatient and outpatient care reported to the department multiplied by the per diem rate that when multiplied by hospital's reported indigent care equals amount that would be payable via Medicaid program for hospitals' total reported indigent care
- Calculating each hospital's annual distribution by multiplying their indigent care factor by the total money allocated to all hospitals within a given pool
- Indigent care data to be used shall be data reported by hospitals for indigent care services rendered during 12-month period ending June 30 of each year as reported by the hospital to DMS by August 15

University hospital distributions.

- Utilizing an acute care university hospital's DRG rate to determine the hospital's indigent care costs pursuant to KRS 205.640(3)(d)1
- Annually calculating an indigent care factor for each hospital by calculating each hospital's percent of indigent care cost of total indigent care cost for all hospitals within same pool (*indigent care cost means inpatient and outpatient care reported to the department* multiplied by the DRG rate (whether if it is a DRG hospital or if partly a DRG hospital and partly a per diem hospital) that when multiplied by hospital's reported indigent care equals amount that would be payable via Medicaid program for the hospitals' total reported indigent care

- Calculating each hospital's annual distribution by multiplying their indigent care factor by the total money allocated to all hospitals within a given pool
- Indigent care data to be used shall be data reported by hospitals for indigent care services rendered during 12-month period ending June 30 of each year as reported by the hospital to DMS by August 15

These changes are necessary to update Medicaid reimbursement for inpatient hospital services to ensure they comply with Centers for Medicare and Medicaid Services (CMS) requirements, Kentucky law, including law governing the use of provider tax funds to enhance inpatient hospital reimbursement, and to align hospital reimbursement with more current cost data.

DMS projects that the DRG reimbursement changes will cost approximately $8.5 million ($5.91 million federal funds; $2.59 million state funds) annually; that the per diem hospital reimbursement changes will cost approximately $1.5 million ($1.04 million federal funds; $0.46 million state funds) annually and that the disproportionate share hospital changes will have no fiscal impact.

Public Comment

A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below. Comments or inquiries may be submitted in writing within thirty (30) days to:

Shawn Crouch, Commissioner
Department for Medicaid Services
275 E. Main Street
Frankfort, Kentucky 40621